| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 15G392 | A. BUILDING 00<br>B. WING | 09/30/2011 |

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| CARDINAL SERVICES INC OF INDIANA | 308 WEST MAIN ST<br>SILVER LAKE, IN46982 |

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| W0000 | This visit was for the pre-determined full recertification and state licensure survey. This visit resulted in Immediate Jeopardy findings at W122 and W318 which were not removed.<br><br>Dates of survey: September 26, 27, 28, 29, and 30, 2011.<br><br>Surveyor: Susan Eakright, Medical Surveyor III/QMRP.<br><br>Provider Number: 15G392<br>Facility Number: 000906<br>AIM Number: 100235160<br><br>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.<br>Quality Review completed 10/3/11 by Ruth Shackelford, Medical Surveyor III. | W0000 | | |
| W0102 | The facility must ensure that specific governing body and management requirements are met.<br><br>Based on observation, record review, and interview, the Condition of Participation: | W0102 | **W102** The facility must ensure that specific governing body and management requirements are met. Cardinal Services, Inc. | 10/10/2011 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | Governing Body and Management was not met as the governing body failed to exercise operating direction over the facility to ensure the Condition of Participation: Client Protections was met for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8); and to ensure the Condition of Participation: Health Care Services was met for 3 of 8 clients (clients #1, #3, and #7). The governing body failed to ensure implementation of the agency's policy and procedure for abuse, neglect, and mistreatment prevention, and failed to ensure the facility immediately reported incidents of abuse, neglect, mistreatment, and injuries of unknown origin. The governing body failed to ensure implementation of effective corrective action to protect clients from physical aggression, allegations of abuse, neglect, and/or mistreatment systemically. The governing body failed to provide systemic oversight of the group home to ensure clients' rights, staff retraining, and medication administration.<br><br>Findings include:<br><br>Please see W104. The governing body failed to ensure implementation of their policy and procedures for 1 of 2 clients (client #5) who demonstrated PICA (eating inedible items) behavior. The governing body failed to ensure client #5 | | strives to meet and be in compliance with all of the conditions of participation established by the Secretary of Health and Human Services. This allegation of compliance is intended to show Cardinal Services' commitment to quality delivery of services. Proactive strategies and corrective action will be developed as needed to avoid further incidents. It is Cardinal Services' belief that the corrective action taken by management staff and the QDP has resolved the Immediate Jeopardy created in the full recertification survey dated September 26, 27, 28, 29 and 30, 2011. The following citations with POAs will be monitored by the governing body to ensure follow up and compliance is in place. Please see W104 Please see W122 Please see W318 | |

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| | was provided sufficient supervision to prevent the identified PICA behavior and failed to ensure the facility implemented effective action to address the PICA behavior. The governing body neglected to follow their policy and procedures for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) who lived in the group home, to immediately report and investigate client #1's unknown bruises identified on 9/26/11, and to develop interventions to protect clients #1, #2, #3, #4, #5, #6, #7, and #8 from client #3 and #8's potential for physical aggression.<br><br>Please refer to W122. The governing body failed to meet the Condition of Participation: Client Protections, for 1 of 2 clients (client #5) who had PICA (eating inedible items) behavior. The facility neglected to develop and implement effective interventions to protect the client and to ensure sufficient supervision of client #5 to address the identified PICA behavior. The governing body neglected to follow their policy and procedures for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) who lived in the group home, to immediately report and investigate client #1's unknown bruises identified on 9/26/11, and to develop interventions to protect clients #1, #2, #3, #4, #5, #6, #7, and #8 from client #3 and #8's potential for physical aggression. | | | |

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| | Please refer to W318. The governing body failed to meet the Condition of Participation: Health Care Services, as the governing body failed to provide adequate health care monitoring by the nursing services and oversight of medication administration for 3 of 8 clients (clients #1, #3, and #7) with significant medication errors.<br><br>9-3-1(a) | | | |
| W0104 | The governing body must exercise general policy, budget, and operating direction over the facility.<br><br>Based on observation, record review, and interview, the governing body failed to ensure implementation of their policy and procedures for 1 of 2 clients (client #5) who demonstrated PICA (eating inedible items) behavior. The governing body failed to ensure client #5 was provided sufficient supervision to prevent the identified PICA behavior and failed to ensure the facility implemented effective action to address the PICA behavior. The governing body failed to ensure implementation of the agency's policy and procedure for abuse, neglect, and mistreatment prevention (clients #1, #2, | W0104 | **W104** The governing body must exercise general policy, budget and operating direction over the facility. Cardinal Services, Inc. strives to meet and be in compliance with all of the conditions of participation established by the Secretary of Health and Human Services. This allegation of compliance is intended to show Cardinal Services' commitment to quality delivery of services. Proactive strategies and corrective action will be developed as needed to avoid further incidents. It is Cardinal Services' belief that the corrective action taken by management staff and the QDP has resolved the Immediate | 10/10/2011 |

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| | #3, #4, #5, #6, #7 and #8), and failed to ensure the facility immediately reported incidents of abuse, neglect, mistreatment, and injuries of unknown origin. The governing body failed to ensure implementation of effective corrective action to protect clients from physical aggression, allegations of abuse, neglect, and/or mistreatment systemically. The governing body failed to provide systemic oversight of the group home to ensure clients' rights, staff retraining, and medication administration.<br><br>Findings include:<br><br>Please see W149. The governing body neglected to follow their policy and procedures for 1 of 2 clients (client #5) who demonstrated PICA (eating inedible items) behavior. The facility neglected to provide sufficient supervision of client #5 to prevent the identified PICA behavior and neglected to implement effective action to address the PICA behavior.<br><br>The governing body neglected to follow their policy and procedures for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) who lived in the group home, to immediately report and investigate client #1's unknown bruises identified on 9/26/11 and to develop interventions to | | Jeopardy created in the full recertification survey dated September 26, 27, 28, 29 and 30, 2011. The following citations with POAs will be monitored by the governing body to ensure follow up and compliance is in place. Please see W149 Please see W153 Please see W157 Please see W331 | |

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| | protect clients #1, #2, #3, #4, #5, #6, #7, and #8 from client #3 and #8's potential for physical aggression.<br><br>Please see W153. The governing body failed for 1 of 1 unknown injury observed (client #1), to immediately report client #1's hand bruise to the administrator and to BDDS (Bureau of Developmental Disability Services) in accordance with state law.<br><br>Please see W157. The governing body failed to implement effective corrective action for 1 of 2 clients (client #5) who demonstrated PICA (eating inedible items) behavior.<br><br>Please see W331. The governing body failed to exercise operating direction over the facility's nursing services to provide adequate health care monitoring and oversight of medication administration for 3 of 8 clients (clients #1, #3, and #7) with significant medication errors.<br><br>9-3-1(a) | | | |

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| W0122 | The facility must ensure that specific client protections requirements are met.<br><br>Based on observation, interview, and record review, the facility failed to meet the Condition of Participation: Client Protections, for 1 of 2 clients (client #5) who had PICA (eating inedible items) behavior. The facility neglected to develop and implement effective interventions to protect the client and to ensure sufficient supervision of client #5 to address the identified PICA behavior.<br><br>This noncompliance resulted in an IMMEDIATE JEOPARDY. The immediate jeopardy was identified on 9/27/11 at 9:10am. The immediate jeopardy began on 8/30/11 when the facility staff neglected to implement the agency policy and procedure for abuse, neglect, and mistreatment. The facility staff neglected to provide effective staff supervision and failed to protect client #5 from her identified PICA behavior. The facility staff failed to develop and implement effective corrective interventions to address client #5's continued PICA behavior. The Agency's Residential Coordinator (RC) was notified of the Immediate Jeopardy on 9/27/11 at 9:10am.<br><br>During monitoring observations at the facility owned day service on 9/28/11 from 12:15pm until 1:10pm, client #5 was observed to sit on the floor in the program room, licked a magazine, chewed on the corners of the pages of a magazine, licked | W0122 | **W122** The facility must ensure that specific client protections requirements are met. Cardinal Services, Inc. strives to meet and be in compliance with all of the conditions of participation established by the Secretary of Health and Human Services. This allegation of compliance is intended to show Cardinal Services' commitment to quality delivery of services. Proactive strategies and corrective action will be developed as needed to avoid further incidents. It is Cardinal Services' belief that the corrective action taken by management staff and the QDP has resolved the Immediate Jeopardy created in the full recertification survey dated September 26, 27, 28, 29 and 30, 2011. The following citations with POAs will be monitored by the governing body to ensure follow up and compliance is in place. Please see W149 Please see W153 Please see W157 | 10/10/2011 |

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her nose with her tongue, picked lint from the floor and ate the lint. Client #5 was not observed to be redirected each time by facility staff. The Immediate Jeopardy was not removed.

Based on observation, interview, and record review, the facility neglected to follow their policy and procedures for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) who lived in the group home, to immediately report client #1's unknown bruises identified on 9/26/11, and to develop interventions to protect clients #1, #2, #3, #4, #5, #6, #7, and #8 from client #3 and #8's potential for physical aggression.

Findings include:

Please refer to W149. The facility neglected to follow their policy and procedures for 1 of 2 clients (client #5) to address the identified PICA behavior. The facility neglected to provide sufficient staff supervision of client #5 and to implement effective action to prevent client #5's behavior. The facility neglected to follow their policy and procedures for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) who lived in the group home, to immediately report client #1's unknown bruises identified on 9/26/11 and to develop interventions to protect clients #1, #2, #3, #4, #5, #6, #7, and #8 from client #3 and #8's potential for physical aggression.

Please refer to W153. The facility failed to immediately report client #1's hand bruise to the administrator and to BDDS (Bureau of Developmental Disability Services) in accordance with state law for 1 of 1 unknown injury observed (client #1).

Please refer to W157. The facility failed to

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| | implement effective corrective action for 1 of 2 clients (client #5) who demonstrated PICA (eating inedible items) behavior.<br><br>9-3-2(a) | | | |
| W0137 | The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.<br><br>Based on observation, record review, and interview, for 4 of 4 sample clients (clients #1, #2, #3, and #4) and for 3 additional clients (clients #6, #7, and #8), the facility failed to allow unimpeded access to shampoo and cream rinse.<br><br>Findings include:<br><br>On 9/27/11 from 5:10am until 8:10am, observation and interviews were completed at the group home with clients #1, #2, #3, #4, #6, #7, and #8. On 9/27/11 at 5:37am, client #1 entered the medication closet, and handed a bottle of shampoo and cream rinse to DCS (Direct Care Staff) #1. DCS #1 unlocked the medication closet and placed the two bottles on the top shelf inside the locked medication closet. At 5:37am, DCS #1 stated she was "unsure" why the shampoo and cream rinse were kept in the locked closet. At 5:50am, DCS #1 indicated the big bottles of shampoo and cream rinse were kept inside the locked medication room. DCS #1 indicated clients #1, #2, #3, #4, #6, #7, and #8 had smaller bottles each client refilled from the large supply bottle. At 6am, clients #6 and #7 | W0137 | **W137** The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing On 09/28/2011 the large bottles of shampoo and conditioner were removed from behind the locked door and placed in the outer closet fully accessible to each of the women in the home. Staff in the home received verbal training from the Residential Manager regarding the right of each of the women to have full access to personal care products. All staff will be formally trained regarding the right of each of the women to have full access to personal care products by October 10, 2011. To ensure this deficiency does not occur again, the Residential Manager, QDP and Residential Coordinator will monitor the availability of personal | 10/10/2011 |

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| | stated they "ask staff" for shampoo and indicated they did not have shampoo or cream rinse.<br><br>On 9/28/11 at 11:50am, an interview with the RC (Residential Coordinator) and the QMRP (Qualified Mental Retardation Professional) was completed. The RC and QMRP indicated clients #1, #2, #3, #4, #6, #7, and #8 did not have an identified need for the secured personal care supplies.<br><br>Client #1's record was reviewed on 9/27/11 at 11:30am. Client #1's 6/2/11 ISP (Individual Support Plan) and record did not indicate an identified need for secured personal items.<br><br>Client #2's records were reviewed on 9/28/11 at 1:20pm. Client #2's 5/11/11 ISP and record did not indicate an identified need for secured personal items.<br><br>Client #3's records were reviewed on 9/27/11 at 10:45am. Client #3's 4/4/11 ISP and record did not indicate an identified need for secured personal items.<br><br>Client #4's record was reviewed on 9/27/11 at 12:20pm. Client #4's 9/9/11 ISP and record did not indicate an identified need for secured personal items.<br><br>9-3-2(a) | | possessions and specifically personal care products. (see attachment A) Residential Manager, QDP and Residential Coordinator responsible. | |
| W0149 | The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br><br>Based on observation, record review, and | W0149 | **W149** The facility must develop and implement written policies and procedures that prohibit | 10/03/2011 |

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| | interview, the facility neglected to follow their policy and procedures for 1 of 2 clients (client #5) who demonstrated PICA (eating inedible items) behavior. The facility neglected to provide sufficient supervision of client #5 to prevent the identified PICA behavior and neglected to implement effective action to address the PICA behavior.<br><br>Based on observation, record review, and interview, the facility neglected to follow their policy and procedures for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) who lived in the group home, to immediately report client #1's unknown bruises identified on 9/26/11 and to develop interventions to protect clients #1, #2, #3, #4, #5, #6, #7, and #8 from client #3 and #8's potential for physical aggression.<br><br>Findings include:<br><br>1. On 9/26/11 at 11:20am, a review of the facility's Bureau of Developmental Disability Services (BDDS) reports from 10/1/10 through 9/26/11 was completed and indicated one (1) report for client #5's PICA behavior:<br>-An 8/30/11 BDDS report, for an incident on 8/30/11 at 8:30am indicated client #5 ingested two (2) "metal tags" and "scratched (her) teeth." The report | | mistreatment, neglect or abuse of the client. Client #5's Self-Management Plan was revised to better define PICA and to clarify the level of staff supervision and interventions. (see attachment B) On 09/28/2011 a tracking sheet noting specific PICA behavior and requiring that staff document ingested items was created. (see attachment C) On 09/28/2011 staff in the group home was trained on the amended plan and the additional tracking sheet. (see attachments B and C) On 10/03/2011 staff in the facility based Day Program were trained on the amended plan and additional tracking sheet. (see attachment D). On 09/28/2011 group home staff was retrained on Cardinal Services Inc. Incident/Abuse/Neglect Policy which contains the guidelines for incident reporting.(see attachment E). The Residential Manager and group home staff will be trained specifically on reporting injuries of unknown origin by October 10, 2011. On 09/27/2011 group home staff were alerted to notify the Adult Services Director of all significant events such as falls, medication errors and injuries. (see attachment F) On 09/28/2011Client #8's IDT amended Client #8's support plan to include that "If peer enters the (bed)room assigned staff will remain with (Client #8) to ensure | |

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| | indicated client #5 was seen at the local medical clinic.<br><br>On 9/27/11 at 9:35am, an interview with the House Manager was completed. The House Manager indicated the medical clinic said to watch client #5 for distress and to monitor client #5's bowel movements.<br><br>During observation at the facility owned day service on 9/28/11 from 12:15pm until 1:10pm, client #5 was observed to sit on the floor in the program room, licked a magazine, chewed on the corners of the pages of a magazine, licked her nose with her tongue, picked lint from the floor and ate the lint. Client #5 was not observed to be redirected each time by facility staff.<br><br>On 9/26/11 at 6pm, client #5's 10/2010 SMP (Self Management Plan) was reviewed at the group home. Client #5's SMP indicated she had a targeted behavior of "PICA-This occurs when I am eating items that are not food ex. (example) shoe strings and clothing tags. At times I have licked floors, windows, walls, or tables while out in the community. I will also take food out of the trash can. If staff tries to intervene when I am doing these things, I may become aggressive." Client #5's SMP indicated "staff will attempt to provide me | | that monitoring plan is followed." Staff will stay in the bedroom with (Client #8) and her roommate until Client #8 is asleep. Once Client # 8 is asleep staff will continue to complete 10 minute bed checks to ensure for the safety of Client #4. (see attachment G) On 09/30/2011 Client #8's Self-Management Plan was amended to reflect the IDT recommendations. (see attachment G) Additionally, on 09/30/2011 group home staff were retrained on Client #8's Self-Management Plan to clarify that staff will redirect Client #8 "to move to a different area where I will not be bothered by the noise … and start an activity that I enjoy" (see attachment H) The IDT reviewed Client #3's Self-Management Plan, particularly interventions strategies for Client #3's physical aggression and self-injurious behavior and the use of a Human Rights Committee approved support hold for the protection of Client #3 and Clients #1,#2, #4, #5, #6, #7 and #8. The IDT determined that Client #3 has a need for ongoing behavioral intervention as well as psychotropic medications and has a history that indicates an overall improvement in functioning with this current plan in place. The use of an occasional, short duration hold after all other interventions have been attempted has proved to be effective to prevent harm to | |

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| | with needed comfort and nurturing by using other, more acceptable activities" to prevent PICA. Client #5's SMP did not indicate the level of supervision staff were to provide.<br><br>On 9/27/11 at 11:45am, client #5's "Behavior Tracking Sheet" was reviewed and indicated the following totals for incidents of PICA behavior: 8/2011--15, 7/2011--20, 6/2011--23, 5/2011--45, 4/2011--34, and 3/2011--31. Client #5's "Behavior Tracking Sheet" neglected to indicate what items client #5 ingested.<br><br>On 9/27/11 at 11:45am, client #5's 9/2/11 "Psychiatric Medication Review" was reviewed. Client #5's Psychiatric Review signed by her psychiatrist indicated the following PICA incidents: "2010-2011 Primary Targeted Behaviors...PICA" 7/2011--49, 6/2011--62, 5/2011--41, 4/2011--128, 3/2011--31, 2/2011--25, 1/2011--28, 12/2010--2, 11/2010--8, and 10/2010--7. The Psychiatric Medication Review neglected to indicate what items client #5 ingested.<br><br>On 9/28/11 at 1:15pm, the QMRP (Qualified Mental Retardation Professional) and the Residential Coordinator (RC) provided an additional undated "Psychiatric Medication Review/Addendum" and stated "this | | Client #3 as well as Clients #1, #2, #4, #5, #6, #7 and #8, and is appropriate to continue. The IDT determined that no changes should be made to Client #3's plan at this time. (see attachment I) Group home staff received specific training on the use of the approved support hold by reviewing the Cardinal Services Inc. Self-Management Policy (attachemnt J) and Client #3's Self-Management Plan (attachment K)on 09/27/2011. The QDP also provided physical demonstration of the support hold to all group home staff on 09/27/2011 (see attachment L). To ensure this deficiency does not occur again, the Residential Manager, QMRP and Residential Coordinator will monitor the implementation of all individualized plans through daily, weekly, monthly and quarterly written observations. **QDP, Residential Manager and Residential Coordinator Responsible.** | |

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| | documents the newly revised totals" for client #5's PICA behavior. The QMRP stated she "reviewed the totals" from the behavior tracking sheet and psychiatric medication review and "changed the totals." The revised form indicated the following: "2010-2011 Primary Targeted Behaviors...PICA" 8/2011--15, 7/2011--20, 6/2011--62, 5/2011--41, 4/2011--128, 3/2011-- 31, 2/2011-- 25, 1/2011--28, 12/2010--2, 11/2010--8, and 10/2010--7. The undated form indicated client #5 had a "major PICA occurrence 8/31/2011, she ate the metal tags from electronic devices. [Client #5] continues to be under close observation due to daily attempts to gain access to food items. PICA has continued with attempts presented daily...[Client #5] must be observed at all times to prevent access to food and inedibles that she attempts to access. Behaviors are increasing in intensity. She has a history of eating glass, screws, and other dangerous items." The revised undated Psychiatric Medication Review neglected to indicate what items client #5 had ingested.<br><br>On 9/27/11 at 9:35am, an interview with the Residential Coordinator (RC) and the House Manager (HM) was completed. The RC and the HM both indicated client #5 should have been supervised to protect her from eating inedibles. The RC | | | |

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| | indicated client #5 ingested the metal tags and was seen at the local medical clinic. The RC stated the staff "neglected to supervise" client #5 when the staff knew client #5 would eat items which were not meant for consumption. The RC indicated he did not know why client #5's "Behavior Tracking Sheets" and the "Psychiatric Medication Review" behavior totals for PICA behaviors did not match. The RC stated "go by the Psychiatric Review" document. The RC indicated he could not identify the specific inedible PICA items client #5 ingested during the past year. The RC indicated no other BDDS reports were available for review.<br><br>The facility's 4/10 Policy for the Prevention and Resolution of Abuse, Neglect, and Mistreatment of Individuals was reviewed on 9/26/11 at 12pm, and indicated "[The name of the Agency] is committed to ensuring the safety, dignity, and protection of persons served...Neglect: Incidents involving persons served which could be construed as neglect...depriving a person served of necessary support...."<br><br>On 9/26/11 at 12noon, a review was completed of the "Bureau of Developmental Disability Services Policy and Guidelines," dated 10/05. The BDDS | | | |

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| | policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual."<br><br>2. On 9/26/11 at 11:20am, a review of the facility's Bureau of Developmental Disability Services (BDDS) reports from 10/1/10 through 9/26/11 was completed for client #1 and did not indicate a report for a left hand bruise.<br><br>On 9/26/11 from 3:45pm until 6:10pm, client #1 was observed to have a bruise on her left hand which covered her lower portion of her middle finger and hand knuckle. On 9/27/11 from 5:10am until 8:15am, client #1 was observed at the group home and had a bruise on her left hand which covered her lower portion of her middle finger and hand knuckle. At 5:37am, DCS (Direct Care Staff) #1 administered client #1's medications. The surveyor asked client #1 about a bruise on the client's hand. DCS #1 stated "She sat on it over the weekend, didn't you [client #1]?" Client #1 stated "I sat on it and did it." DCS #1 stated client #1's bruise was "black, blue, and green." DCS #1 stated client #1's hand bruise was "approximately four (4") inches from the | | | |

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| | hand up client #1's middle finger and about three (3") inches wide."<br><br>On 9/27/11 at 9:35am, an interview with the RC and the HM was completed. The RC and the HM both indicated client #1's bruise had not been reported to the administrator or to BDDS. Both indicated no report was available for review. Both indicated client #1's hand injury should have been reported immediately.<br><br>3. On 9/26/11 at 11:20am, a review of the facility's Bureau of Developmental Disability Services reports from 10/1/10 through 9/26/11 was completed and indicated the following for client to client physically aggressive behaviors.<br><br>-On 7/24/11 at 4pm, client #3 was "frustrated with a peer" and attempted to bite and hit staff and unidentified peers. Staff applied a physical support hold and no injury was reported.<br><br>-On 7/19/11 at 4:30pm, client #3 was biting herself and was physically aggressive. Staff applied a physical support hold and no injury was reported.<br><br>-On 7/12/11 at 5:45pm, client #3 was physically aggressive "toward others." Staff applied a two person physical support hold and no injury was reported. | | | |

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-On 7/12/11 at 9:30am, client #3 was nude, exited the bathroom, and became physically aggressive. Staff applied a physical support hold and no injury was reported.

-On 6/11/11 at 10:45am, client #3 was "obsessive over a peer" and left AWOL from the group home "toward the road." Staff applied a physical support hold and no injury was reported.

-On 5/17/11 at 8:30am, client #3 was "frustrated" and wanted to wash her bedding. The washer was in operation and client #3 became physically aggressive. Staff applied a physical support hold and no injury was reported.

-On 5/10/11 at 9:15am, client #3 soiled her clothing, exited the bathroom nude, and became physically aggressive. Staff applied a physical support hold and a two person lift back to the bathroom and no injury was reported.

-On 5/2/11 at 12:20pm, client #3 exited the bathroom nude and became physically aggressive. Staff applied a physical support hold and no injury was reported.

-On 3/30/11 at 9:45am, client #3 exited the bathroom nude and became physically

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| | aggressive. Staff applied a physical support hold and no injury was reported.<br><br>-On 3/8/11 at 4pm, client #3 became physically aggressive. Staff applied a physical support hold and no injury was reported.<br><br>-On 3/2/11 at 8pm, client #3 was "obsessive over peer" and became aggressive with peer. Staff applied a physical support hold and no injury was reported.<br><br>-On 1/23/11 at 4:35pm, client #3 "attempted to bite [client #1]." Staff applied a physical support hold and no injury was reported.<br><br>-On 7/18/11 at 7:45pm, clients #4 and #8 were inside their shared bedroom which had a audio monitor in operation. The report indicated staff heard noises from the audio monitor, went to client #4 and #8's shared bedroom, and client #8 was standing over client #4 who was sitting upright in her bed rubbing one of her arms. The report indicated at 8:30am on 7/19/11 client #4 had "two (2) bruises" on her right arm and one bruise on client #4's left arm. The report indicated client #4's had three bruises and each bruise measured "2" x 3" (two inches by three inches)." The report indicated a | | | |

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| | recommendation from the IDT (Interdisciplinary Team) for "bed checks every ten (10) minutes."<br><br>On 9/27/11 at 9:35am, an interview with the RC and the HM was completed. The RC and the HM stated clients #3 and #8 had "long standing physically aggressive behaviors." The HM and RC both indicated clients #4 and #8 had limited verbal skills. The HM stated "That's why we have a audio monitor in her bedroom." The HM stated when the staff on duty heard the noises in client #4 and #8's shared bedroom, staff went immediately to inquire, and staff removed client #4 from the bedroom for "about an hour" before client #4 returned to bed. The HM stated the staff "said there was no injury that night." The HM indicated client #4 had injuries to both arms the next morning from client #8's physical aggression. The RC and HM indicated client #3 "would have gotten a hold" of other clients "if staff would not have applied the physical holds" during client #3's physically aggressive behaviors.<br><br>On 9/26/11 from 5:15pm until 5:25pm, client #8 threw her purse across the living room hitting the walls and the furniture, picked up her purse, threw the purse again repeatedly, and no redirection was observed. From 5:15pm until 5:25pm, | | | |

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| | client #8 physically hit the living room television with her hands and a thump each time could be heard. From 5:15pm until 5:25pm, client #8 was observed by Direct Care Staff (DCS) #3 and no redirection was observed for client #8's physically aggressive behaviors. At 5:25pm, DCS #3 stated "she's (client #8) hands off" and no redirection for client #8 was observed.<br><br>The facility's 4/10 Policy for the Prevention and Resolution of Abuse, Neglect, and Mistreatment of Individuals was reviewed on 9/26/11 at 12pm, and indicated "[The name of the Agency] is committed to ensuring the safety, dignity, and protection of persons served. To ensure that physical, mental, sexual abuse, neglect, or exploitation of persons served by staff members, other persons served, or others will not be tolerated, incidents will be reported and thoroughly investigated. 431 IAC 1-1-3-1 obligates [Facility name] to report to the Bureau of Developmental Disabilities Services/BDDS and Adult Protective Services (APS) any suspicion or allegation of neglect or abuse whether that suspicion or allegation is based upon fact or not. The agency may not screen such allegations...Physical abuse/sexual abuse: Suspected, alleged, or confirmed physical or sexual abuse of a person served. This includes: forced physical | | | |

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| | activity, willful infliction of injury, by hitting, pinching, or kicking, physical restraints, using painful noxious stimuli...physical harm or pain...Neglect: Incidents involving persons served which could be construed as neglect...depriving a person served of necessary support...The reporting staff must always report all incidents immediately to an on call supervisor. That supervisor will report all incidents to the Department Coordinator for further follow up...All injuries of unknown origin and allegations of abuse, neglect, and mistreatment must be reported to the Administrator immediately."<br><br>On 9/26/11 at 12noon, a review was completed of the "Bureau of Developmental Disability Services Policy and Guidelines," dated 10/05. The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse by anyone including but not limited to facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or | | | |

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| | psychological harm to the individual."<br><br>9-3-2(a) | | | |
| W0153 | The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.<br><br>Based on observation, record review, and interview, for 1 of 1 unknown injury observed (client #1), the facility failed to immediately report client #1's hand bruise to the administrator and to BDDS (Bureau of Developmental Disability Services) in accordance with state law.<br><br>Findings include:<br><br>On 9/26/11 at 11:20am, a review of the facility's Bureau of Developmental Disability Services reports from 10/1/10 through 9/26/11 was completed for client #1 and did not indicate a report for a left hand bruise.<br><br>On 9/26/11 from 3:45pm until 6:10pm, client #1 was observed to have a bruise on her left hand which covered her lower portion of her middle finger and hand knuckle. On 9/27/11 from 5:10am until 8:15am, client #1 was observed at the group home and had a bruise on her left hand which covered her lower portion of her middle finger and hand knuckle. At 5:37am, DCS (Direct Care Staff) #1 administered client #1's medications. The surveyor asked client #1 about a bruise on the | W0153 | **W153** The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Cardinal Services, Inc. is committed to providing quality services and a safe environment free from abuse, neglect and mistreatment for the people that we provide supports for. Cardinal Services, Inc. ensures that staff are trained regarding the prevention of abuse and neglect and the incident reporting guidelines by providing “Prevention of Abuse and Neglect” foundations training during the new hire process. In addition to this, Cardinal Services, Inc. staff receive annual training regarding abuse prevention along with annual review of the | 10/10/2011 |

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| | client's hand. DCS #1 stated "She sat on it over the weekend, didn't you [client #1]?" Client #1 stated "I sat on it and did it." DCS #1 stated client #1's bruise was "black, blue, and green." DCS #1 stated client #1's hand bruise was "approximately four (4") inches from the hand up client #1's middle finger and about three (3") inches wide."<br><br>On 9/27/11 at 9:35am, an interview with the RC and the HM was completed. The RC and the HM both indicated client #1's bruise had not been reported. Both indicated no report was available for review. Both indicated client #1's hand injury should have been reported immediately.<br><br>9-3-2(a) | | Incident/Abuse/Neglect policy. Group home staff were re-trained on the Incident/Abuse/Neglect Policy which includes reporting all incidents of abuse/neglect/mistreatment and unknown origin to the administrator immediately. All 14 West staff were re-trained on Cardinal Services, Inc. Incident/Abuse/Neglect Policy on 09/27/2011. (see attachment E) On 09/27/2011 group home staff were alerted to notify the Adult Services Director of all significant events such as falls, medication errors and injuries. (see attachment F)14 West staff will be required to demonstrate competency regarding incident reporting by completing an Incident Reporting Quiz by 10/10/2011. The QMRP, Residential Manager and Residential Coordinator will continue to monitor the treatment of persons served through weekly, monthly and quarterly observations to ensure this deficiency does not occur again in the future. QMRP, Residential Manager and Residential Coordinator Responsible. | |
| W0157 | If the alleged violation is verified, appropriate corrective action must be taken.<br><br>Based on observation, record review, and interview, the facility failed to implement effective corrective action for 1 of 2 clients (client #5) who demonstrated PICA (eating inedible items) behavior. | W0157 | W157 If the alleged violation is verified, appropriate corrective action must be taken. Client #5's Self-Management Plan was revised to better define PICA and to clarify the level of staff supervision and interventions. | 10/03/2011 |

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| | Findings include:<br><br>On 9/26/11 at 11:20am, a review of the facility's Bureau of Developmental Disability Services (BDDS) reports from 10/1/10 through 9/26/11 was completed and indicated one (1) report for client #5's PICA behavior:<br>-An 8/30/11 BDDS report, for an incident on 8/30/11 at 8:30am indicated client #5 ingested two (2) "metal tags" and "scratched (her) teeth." The report indicated client #5 was seen at the local medical clinic.<br><br>On 9/27/11 at 9:35am, an interview with the House Manager was completed. The House Manager indicated the medical clinic said to watch client #5 for distress and to monitor client #5's bowel movements.<br><br>During observation at the facility owned day service on 9/28/11 from 12:15pm until 1:10pm, client #5 was observed to sit on the floor in the program room, licked a magazine, chewed on the corners of the pages of a magazine, licked her nose with her tongue, picked lint from the floor and ate the lint. Client #5 was not observed to be redirected each time by facility staff.<br><br>On 9/26/11 at 6pm, client #5's 10/2010 SMP (Self Management Plan) was reviewed at the group home. Client #5's SMP indicated she had a targeted behavior of "PICA-This occurs when I am eating items that are not food ex. (example) shoe strings and clothing tags. At times I have licked floors, windows, walls, or tables while out in the community. I will also take food out of the trash can. If staff tries to intervene when I am doing these things, I may become aggressive." Client #5's SMP indicated "staff will attempt to provide | | (see attachment B) On 09/28/2011 a tracking sheet noting specific PICA behavior and requiring that staff document ingested items was created. (see attachment C) On 09/28/2011 staff in the group home was trained on the amended plan and the additional tracking sheet. (see attachments B and C) On 10/03/2011 staff in the facility based Day Program were trained on the amended plan and additional tracking sheet. (see attachment D). The QDP will use the specific PICA data collected to report ingested items to Client #5's Psychiatrist on the Psychiatric Medication Review form. (see attachment M) To ensure this deficiency does not occur again, the Residential Manager, QDP and Residential Coordinator will monitor the implementation of all individualized plans through daily, weekly, monthly and quarterly written observations. The Support Services Coordinator and Nurse will ensure that all applicable data is correctly entered on the Psychiatric Medication Review form through review of documents. **Support Services Coordinator, Residential Nurse, QDP, Residential Manager and Residential Coordinator Responsible** | |

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| | me with needed comfort and nurturing by using other, more acceptable activities" to prevent PICA. Client #5's SMP did not indicate the level of supervision staff were to provide.<br><br>On 9/27/11 at 11:45am, client #5's "Behavior Tracking Sheet" was reviewed and indicated the following totals for incidents of PICA behavior: 8/2011--15, 7/2011--20, 6/2011--23, 5/2011--45, 4/2011--34, and 3/2011--31. Client #5's "Behavior Tracking Sheet" neglected to indicate what items client #5 ingested.<br><br>On 9/27/11 at 11:45am, client #5's 9/2/11 "Psychiatric Medication Review" was reviewed. Client #5's Psychiatric Review signed by her psychiatrist indicated the following PICA incidents: "2010-2011 Primary Targeted Behaviors...PICA" 7/2011--49, 6/2011--62, 5/2011--41, 4/2011--128, 3/2011--31, 2/2011--25, 1/2011--28, 12/2010--2, 11/2010--8, and 10/2010--7. The Psychiatric Medication Review neglected to indicate what items client #5 ingested.<br><br>On 9/28/11 at 1:15pm, the QMRP (Qualified Mental Retardation Professional) and the Residential Coordinator (RC) provided an additional undated "Psychiatric Medication Review/Addendum" and stated "this documents the newly revised totals" for client #5's PICA behavior. The QMRP stated she "reviewed the totals" from the behavior tracking sheet and psychiatric medication review and "changed the totals." The revised form indicated the following: "2010-2011 Primary Targeted Behaviors...PICA" 8/2011--15, 7/2011--20, 6/2011--62, 5/2011--41, 4/2011--128, 3/2011-- 31, 2/2011-- 25, 1/2011--28, 12/2010--2, 11/2010--8, and 10/2010--7. The undated form indicated client #5 had a "major PICA occurrence 8/31/2011, she ate the metal tags | | | |

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| | from electronic devices. [Client #5] continues to be under close observation due to daily attempts to gain access to food items. PICA has continued with attempts presented daily...[Client #5] must be observed at all times to prevent access to food and inedibles that she attempts to access. Behaviors are increasing in intensity. She has a history of eating glass, screws, and other dangerous items." The revised undated Psychiatric Medication Review neglected to indicate what items client #5 had ingested.<br><br>On 9/27/11 at 9:35am, an interview with the Residential Coordinator (RC) and the House Manager (HM) was completed. The RC and the HM both indicated client #5 should have been supervised to protect her from eating inedibles. The RC indicated client #5 ingested the metal tags and was seen at the local medical clinic. The RC stated the staff "neglected to supervise" client #5 when the staff knew client #5 would eat items which were not meant for consumption. The RC indicated he did not know why client #5's "Behavior Tracking Sheets" and the "Psychiatric Medication Review" behavior totals for PICA behaviors did not match. The RC stated "go by the Psychiatric Review" document. The RC indicated he could not identify the specific inedible PICA items client #5 ingested during the past year. The RC indicated no other BDDS reports were available for review. The RC and the HM indicated client #5's plan was reviewed and no changes in client #5's plan were available for review.<br><br>9-3-2(a) | | | |
| W0318 | The facility must ensure that specific health care services requirements are met. | | | |

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| | Based on observation, record review, and interview, the Condition of Participation: Health Care Services, was not met as the facility failed to provide adequate health care monitoring and oversight of medication administration for 3 of 8 clients (clients #1, #3, and #7) with significant medication errors.<br><br>This noncompliance resulted in an IMMEDIATE JEOPARDY. The immediate jeopardy was identified on 9/27/11 at 9:10am. The immediate jeopardy began on 6/28/11 when the facility failed to provide nursing oversight, failed to develop effective interventions to prevent further medication errors, and failed to monitor staff passing medications. The Agency's Residential Coordinator (RC) was notified of the Immediate Jeopardy on 9/27/11 at 9:10am. The Immediate Jeopardy was not removed.<br><br>Findings include:<br><br>Please refer to W331. The facility's nursing services failed to provide adequate health care monitoring and oversight of medication administration for 3 of 8 clients (clients #1, #3, and #7) with significant medication errors.<br><br>Please refer to W368. The facility staff failed to administer medications according to physician orders for 3 of 8 clients (clients #1, #3, and #7) with significant medication errors.<br><br>Please refer to W382. The facility failed to maintain proper medication security for 1 of 1 client (client #7) with a personal medication box.<br><br>9-3-6(a) | W0318 | **W 318** The facility must ensure that specific health care services requirements are met Cardinal Services, Inc. strives to meet and be in compliance with all of the conditions of participation established by the Secretary of Health and Human Services. This allegation of compliance is intended to show Cardinal Services' commitment to quality delivery of services. Proactive strategies and corrective action will be developed as needed to avoid further incidents. It is Cardinal Services' belief that the corrective action taken by management staff and the QDP has resolved the Immediate Jeopardy created in the full recertification survey dated September 26, 27, 28, 29 and 30, 2011. The following citations with POAs will be monitored by the governing body to ensure follow up and compliance is in place. Please refer to W331 Please refer to W368 Please refer to W382 | 10/23/2011 |

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| W0331 | The facility must provide clients with nursing services in accordance with their needs.<br><br>Based on observation, record review, and interview, the facility's nursing services failed to provide adequate health care monitoring and oversight of medication administration for 3 of 8 clients (clients #1, #3, and #7) with significant medication errors.<br><br>Findings include:<br><br>On 9/26/11 at 11:20am, a review of the facility's Bureau of Developmental Disability Services reports from 10/1/10 through 9/26/11 was completed and indicated the following for client #1, #3, and #7's medications given in error:<br><br>For client #1:<br>-On 8/19/11 at 1pm, client #1 "was given a peer's" medication of Lamictal 200mg (milligrams) for seizures, Felbatol 600mg for seizures, and Depakote 500mg for seizures. The report indicated staff were to "monitor" client #1.<br>-On 8/19/11 at 8:45pm, client #1 became unsteady and fell. The report indicated client #1 had two (2) bruises on her left knee and four (4) bruises on her left thigh.<br><br>-On 6/28/11 at 6am, client #1 was given "2 (two) doses of Enablex 7.5mg" for blood pressure. The report indicated staff were to monitor client #1.<br><br>For client #3:<br>-On 8/19/11 at 12:40pm, client #3 received a "second dose of Klonopin 0.5mg after meds (medications) were already passed." The report indicated staff were to monitor client #3.<br><br>For client #7: | W0331 | **W331** The facility must provide clients with nursing services in accordance with their needs. In order to assure that specific, accurate communication occurs between the nurse and the physician when a medication error is committed the Medication Error Report form will be revised to include fields for the exact follow up recommendations from the prescribing physician by 10/10/2011. Nurses will be trained on the form revisions by 10/10/2011. In order to assure that Direct Support Professionals are informed of the prescribing physician's recommendations when a medication error has been committed and accurate monitoring occurs, a Client Medication Error Follow Up/Results form will be created by 10/10/2011. This form will include fields for the name of the person served, the exact medication error, the recommendations/follow along orders from the prescribing physician, monitoring results and any noted adverse effects. This form will be reviewed as needed and monthly by the Nurse and then filed in the person served main file. The form will be trained on and implemented by 10/23/2011. In order to ensure that staff are provided with adequate equipment to monitor blood pressure for Clients #1, #2, | 10/23/2011 |

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| | -On 3/7/11 at 6:30pm, client #7 was "given Remeron 45mg (for organic mood disorder) belonging to another client." The report indicated staff were to monitor client #7's blood pressure.<br><br>On 9/27/11 at 6am, clients #1, #2, #3, #4, #5, #6, #7, and #8's group home blood pressure machine used to monitor vital signs which included blood pressure did not operate to monitor clients #4 and #8's vital signs. At 12:30pm, clients #4 and #8's 9/2011 MAR (Medication Administration Records) were reviewed and DCS (Direct Care Staff) #2 and the House Manager both documented on 9/26/11 that "no batteries (were) in B/P cuff" and clients #4 and #8's blood pressures were not able to be completed.<br><br>Client #1's record was reviewed on 9/27/11 at 11:30am. Client #1's 9/2011, 8/2011, and 6/2011 monthly nurses notes did not indicate client #1 had medication errors. Client #1's 7/25/11 "Physician's Order" indicated "Enablex 7.5mg (for blood pressure) take one tablet once daily at 7am" and "Depakote 250mg tablet (for seizures) take one tablet by mouth three times daily with 500mg at 6am, 1pm, and 8pm, Depakote 500mg take one tablet P. O. (orally) in the am (morning)...." Client #1's record did not indicate her blood pressure was monitored after the additional blood pressure medication was given in error. No documented evidence was available for review in client #1's medical record regarding client #1's medication errors, nursing monitoring, nursing follow up, or adverse effects.<br><br>Client #3's record was reviewed on 9/27/11 at 10:45am. Client #3's 9/2011 and 8/2011 monthly nurses notes did not indicate client #3 had a medication error. Client #3's 8/4/11 "Physician's Order" indicated "Klonopin 1mg take 1 tablet by | | #3, #4, #5, #6, #7 and #8 the group home will be equipped with a manual blood pressure cuff and stethoscope by 10/10/2011. In order to assure that all people receiving Residential services through Cardinal Services Inc. receive adequate medical supports each group home will be equipped with a manual blood pressure cuff and stethoscope by 10/10/2011. Ongoing monitoring will occur to ensure consistent implementation through monthly document review by the Residential Manager and Support Services Coordinator. **Support Services Coordinator, Nurse and Residential Manager Responsible** | |

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| | mouth at bed time at 8am (for behaviors)." Client #3's record did not indicate her vital signs were monitored. No documented evidence was available for review in client #3's medical record regarding client #3's medication errors, nursing monitoring, nursing follow up, or adverse effects.<br><br>Client #7's record was reviewed on 9/27/11 at 12:15pm. Client #7's 9/2011, 8/2011, 7/2011, 6/2011, 5/2011, and 4/2011 monthly nurses notes did not indicate client #7 had medication errors. Client #7's 7/25/11 "Physician's Order" indicated "Calcium W/D (with vitamin D) take 1 tablet by mouth twice daily at 7am and 5pm" for nutritional health. Client #7's record did not indicate a physician's order for Remeron for organic mood disorder. Client #7's record did not indicate her vital signs were monitored. No documented evidence was available for review in client #7's medical record regarding client #7's medication errors, nursing monitoring, nursing follow up, or adverse effects.<br><br>On 9/26/11 at 1:50pm, and on 9/27/11 at 9:35am, during interviews with the Residential Coordinator (RC), the facility's medication error reports were requested and no medication error reports were available for review. On 9/26/11 at 1:50pm and on 9/27/11 at 9:35am, the RC indicated he would locate the reports.<br><br>On 9/28/11 at 2:30pm, the RC provided client #1, #3, and #7's "Medication Error Form" which indicated the following:<br>For client #1:<br>-A Medication Error Report on 8/22/11 for an error on 8/19/11 reported at 1:58pm, indicated client #1 "was given a peer's medications" of Lamictal 200mg (milligrams) for seizures, Felbatol 600mg for seizures, and "she was given Depakote | | | |

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| | 750mg (for seizures) that she is to receive." The report indicated "Treatment: Monitor for 24 (twenty-four) hours, vitals every 4 (four) hours, and watch for dizziness or nausea." No documented monitoring was available for review.<br>-A Medication Error Report on 6/28/11 reported at 7:15am, indicated client #1 was given "2 (two) doses of Enablex (7.5mg) during the med (medication) pas instead of one." The report indicated "Were there any adverse effects from the medication error" was blank and "If yes, please describe: not at this time will be monitoring." No documented monitoring was available for review.<br><br>For client #3:<br>-A Medication Error Report on 8/19/11 reported at 12:40pm, indicated "Medication: Clonazepam (Klonopin) 0.5mg...Lost med or possibly given twice." No documented monitoring was available for review.<br><br>For client #7:<br>-A Medication Error Report on 3/6/11 reported at 6:30pm, indicated "Medication: Remeron 45mg." The report indicated client #7 was "given (Remeron 45mg for organic mood disorder)" which belonged to a different client. No documented monitoring was available for review.<br><br>On 9/27/11 at 9:35am, the RD and the House Manager were interviewed. The RC stated "at least two" medication errors were "significant" medication errors. The RC and the House Manager both indicated clients should have had their vital signs monitored after the medication errors.<br><br>On 9/27/11 at 11:50am, an interview with the Site Director (SD) was completed. The SD indicated the facility did not have documentation the facility | | | |

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| | had retrained staff, met to discuss medications not being administered according to physician orders or documented nursing follow up to the incidents. The SD provided a review of an agency internal document which documented an overall review of the medication errors. The SD indicated the agency's medication errors had decreased over the past year and stated "they're mostly at" this group home and this "group home's medication errors are up." The SD stated the clients "are at risk" because "at least two of the medication errors are significant." The SD indicated the staff and House Manager were responsible for ensuring nursing was notified of the incidents. The SD stated "they're looking for staff training" of corrective action.<br><br>On 9/28/11 at 2:30pm, an interview with the agency LPN (Licensed Practical Nurse), the RC, and the QMRP was completed. The RC and LPN provided documented monitoring by the agency nurse visits to observe medication administration at the group home on 5/19/11, 3/24/11, 3/4/11, 2/12/11, and 7/22/10. The agency LPN and RC stated "the staff involved with the specific medication error was retrained" for medication administration. The RC indicated the agency had a web based training available for staff to complete. The RC and agency LPN indicated staff were scored one to four (1-4) for medication errors. The RC stated if staff acquired a score of eight (8) "for a period of time" the specific staff had to repeat Core A/Core B medication administration training. The RC and LPN indicated they did not consider client #1, #3, and #7's medication errors to have the potential to cause harm. The agency LPN stated she would score client #1, #3, and #4's medication errors as "four (4)." The LPN provided staff training documents for clients #1, #3, and #4's medication | | | |

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| | errors and indicated the staff were retrained on providing medications. The agency LPN stated it was "human error" that clients continued to have medication errors when medications were administered by the facility staff. The LPN stated the specific medication errors for clients #1, #3, and #7 were reported to their personal physician and "no one went to the hospital."<br><br>On 9/30/11 at 2:15pm, the LPN provided client #1 and #3's "Vital" signs completed 8/19/11 and 8/20/11. The LPN indicated client #1 and #3's "Vital" sign record indicated vital signs were not completed for 8/20/11.<br><br>9-3-6(a) | | | |
| W0368 | The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.<br><br>Based on observation, record review, and interview, the facility staff failed to administer medications according to physician orders for 3 of 8 clients (clients #1, #3, and #7) with significant medication errors.<br><br>Findings include:<br><br>On 9/26/11 at 11:20am, a review of the facility's Bureau of Developmental Disability Services reports from 10/1/10 through 9/26/11 was completed and indicated the following for client #1, #3, and #7's medications given in error:<br><br>For client #1:<br>-On 8/19/11 at 1pm, client #1 "was given a peer's" medication of Lamictal 200mg (milligrams) for seizures, Felbatol 600mg for seizures, and | W0368 | **W368** Cardinal Services has an ongoing medication error reduction program. Medication errors are tracked for quarterly analysis. Agency-wide medication errors have been reduced over the past two years as noted in the annual safety analysis (see attachment N). The Medication Error Workteam created an agency-wide survey pertaining to medication errors this year. Environmental, Physical, and Competency factors were all surveyed for each site. Data collected from direct support staff was placed into site-specific action plans to address these factors. The objective of this survey and action plans is to | 10/20/2011 |

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| | 15G392 | A. BUILDING 00<br>B. WING | 09/30/2011 |

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| | Depakote 500mg for seizures. The report indicated staff were to "monitor" client #1.<br>-On 8/19/11 at 8:45pm, client #1 became unsteady and fell. The report indicated client #1 had two (2) bruises on her left knee and four (4) bruises on her left thigh.<br><br>-On 6/28/11 at 6am, client #1 was given "2 (two) doses of Enablex 7.5mg" for blood pressure. The report indicated staff were to monitor client #1.<br><br>For client #3:<br>-On 8/19/11 at 12:40pm, client #3 received a "second dose of Klonopin 0.5mg after meds (medications) were already passed." The report indicated staff were to monitor client #3.<br><br>For client #7:<br>-On 3/7/11 at 6:30pm, client #7 was "given Remeron 45mg (for organic mood disorder) belonging to another client." The report indicated staff were to monitor client #7's blood pressure.<br><br>Client #1's record was reviewed on 9/27/11 at 11:30am. Client #1's 7/25/11 "Physician's Order" indicated "Enablex 7.5mg (for blood pressure) take one tablet once daily at 7am" and "Depakote 250mg tablet (for seizures) take one tablet by mouth three times daily with 500mg at 6am, 1pm, and 8pm, Depakote 500mg take one tablet P. O. (orally) in the am (morning)...." Client #1's record did not indicate her blood pressure was monitored after the additional blood pressure medication was given in error.<br><br>Client #3's record was reviewed on 9/27/11 at 10:45am. Client #3's 8/4/11 "Physician's Order" indicated "Klonopin 1mg take 1 tablet by mouth at bed time at 8am (for behaviors)." Client #3's record did not indicate her vital signs were | | eliminate any barriers in a site that can lead to a medication error.(see attachement O). In order to ensure that staff is familiar with medication administration procedures group home staff were re-trained on Cardinal Services Inc. Medication Policy on 09/27/2011. (see attachment P) Cardinal Services Inc. Day Program staff were retrained on the Medical Policy on 10/03/2011. (see attachment D)<br>To assure that group home staff complete error free medication administration staff must demonstrate medication administration competency by completing two error free medication passes while being observed by a nurse or supervisor. Competency will be confirmed through observation by 10/20/2011. **Residential Manager, Nurse and Residential Coordinator responsible.** | |

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| | monitored.<br><br>Client #7's record was reviewed on 9/27/11 at 12:15pm. Client #7's 7/25/11 "Physician's Order" indicated "Calcium W/D (with vitamin D) take 1 tablet by mouth twice daily at 7am and 5pm" for nutritional health. Client #7's record did not indicate a physician's order for Remeron for organic mood disorder. Client #7's record did not indicate her vital signs were monitored. No documented evidence was available for review in client #7's medical record regarding client #7's medication errors, nursing monitoring, nursing follow up, or adverse effects.<br><br>On 9/26/11 at 1:50pm, and on 9/27/11 at 9:35am, during interviews with the Residential Coordinator (RC), the facility's medication error reports were requested and no medication error reports were available for review. On 9/26/11 at 1:50pm and on 9/27/11 at 9:35am, the RC indicated he would locate the reports.<br><br>On 9/28/11 at 2:30pm, the RC provided client #1, #3, and #7's "Medication Error Form" which indicated the following:<br>For client #1:<br>-A Medication Error Report on 8/22/11 for an error on 8/19/11 reported at 1:58pm, indicated client #1 "was given a peer's medications" of Lamictal 200mg (milligrams) for seizures, Felbatol 600mg for seizures, and "she was given Depakote 750mg (for seizures) that she is to receive." The report indicated "Treatment: Monitor for 24 (twenty-four) hours, vitals every 4 (four) hours, and watch for dizziness or nausea." No documented monitoring was available for review.<br>-A Medication Error Report on 6/28/11 reported at 7:15am, indicated client #1 was given "2 (two) doses of Enablex (7.5mg) during the med | | | |

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| | (medication) pas instead of one." The report indicated "Were there any adverse effects from the medication error" was blank and "If yes, please describe: not at this time will be monitoring." No documented monitoring was available for review.<br><br>For client #3:<br>-A Medication Error Report on 8/19/11 reported at 12:40pm, indicated "Medication: Clonazepam (Klonopin) 0.5mg...Lost med or possibly given twice." No documented monitoring was available for review.<br><br>For client #7:<br>-A Medication Error Report on 3/6/11 reported at 6:30pm, indicated "Medication: Remeron 45mg." The report indicated client #7 was "given (Remeron 45mg for organic mood disorder)" which belonged to a different client. No documented monitoring was available for review.<br><br>On 9/27/11 at 9:35am, the RD and the House Manager were interviewed. The RC stated "at least two" medication errors were "significant" medication errors. The RC and the House Manager both indicated clients should have had their vital signs monitored after the medication errors.<br><br>On 9/27/11 at 11:50am, an interview with the Site Director (SD) was completed. The SD indicated the facility did not have documentation the facility had retrained staff, met to discuss medications not being administered according to physician orders or documented nursing follow up to the incidents. The SD provided a review of an agency internal document which documented an overall review of the medication errors. The SD indicated the agency's medication errors had decreased over the past year and stated "they're mostly at" this group | | | |

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| | home and this "group home's medication errors are up." The SD stated the clients "are at risk" because "at least two of the medication errors are significant." The SD indicated the staff and House Manager were responsible for ensuring nursing was notified of the incidents. The SD stated "they're looking for staff training" of corrective action.<br><br>On 9/28/11 at 2:30pm, an interview with the agency LPN (Licensed Practical Nurse), the RC, and the QMRP was completed. The RC and LPN provided documented monitoring by the agency nurse visits to observe medication administration at the group home on 5/19/11, 3/24/11, 3/4/11, 2/12/11, and 7/22/10. The agency LPN and RC stated "the staff involved with the specific medication error was retrained" for medication administration. The RC indicated the agency had a web based training available for staff to complete. The RC and agency LPN indicated staff were scored one to four (1-4) for medication errors. The RC stated if staff acquired a score of eight (8) "for a period of time" the specific staff had to repeat Core A/Core B medication administration training. The RC and LPN indicated they did not consider client #1, #3, and #7's medication errors to have the potential to cause harm. The agency LPN stated she would score client #1, #3, and #4's medication errors as "four (4)." The agency LPN stated it was "human error" that clients continued to have medication errors when medications were administered by the facility staff. The LPN stated the specific medication errors for clients #1, #3, and #7 were reported to their personal physician and "no one went to the hospital." The LPN indicated client #1, #3, and #7's medications were not given according to physician orders. | | | |

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| | 9-3-6(a) | | | |
| W0382 | The facility must keep all drugs and biologicals locked except when being prepared for administration.<br><br>Based on observation, record review, and interview, for 1 of 1 client (client #7) with a personal medication box, the facility failed to maintain proper medication security.<br><br>Findings include:<br><br>On 9/27/11 from 5:10am until 8:10am, observation and interview were completed at the group home. At 6:50am, client #7 was observed sitting in her wheel chair outside the medication room and held her multi dose medication cards Calcium and Multivitamin. At 6:50am, client #7's medication box was open with the key in the lock to the box was observed on her bed inside her shared bedroom. Client #7's medication box held multi dose medication cards of Calcium with vitamin D (vitamin), Mobic 65mg (for anti inflammatory), Acetaminophen 325mg (for pain or discomfort), Sudafed (for allergies), and Immodium (for diarrhea). From 6:55am, until 7:05am, client #7 entered the medication room with Direct Care Staff (DCS) #1 to complete medication administration. At | W0382 | **W382** The facility must keep all drugs and biologicals locked except when being prepared for administration. In order to ensure that all medications are kept secure, staff in the group home were retrained on Cardinal Services Inc. Medication Policy which includes securing medications on 09/27/2011. (see attachment P) Additionally group home staff will be trained specifically on keeping Client #7's medications secure by 10/10/2011. All Cardinal Services staff will be trained on securing medication by 10/10/2011. Ongoing monitoring will occur to ensure that medications are kept secured through weekly, monthly and quarterly observations by the Residential Manager, QDP, Residential Nurse and Residential Coordinator. **Residential Manager, QDP, Residential Nurse and Residential Coordinator Responsible.** | 11/03/2011 |

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| | 7:05am, the House Manager (HM) indicated client #7's medications should have been secured.<br><br>An interview was conducted on 9/28/11 at 1:15pm, with agency LPN (Licensed Practical Nurse) was completed. The LPN indicated stated "all" medications should be locked when not being administered.<br><br>9-3-6(a) | | | |
| W0436 | The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.<br><br>Based on observation, record review, and interview, for 1 of 3 sample clients (client #3) who wore prescription eye glasses, the facility failed to encourage and teach client #3 to wear her prescribed eye glasses.<br><br>Findings include:<br><br>On 9/26/11 from 3:45pm until 6:10pm, and on 9/27/11 from 5:10am until 8:10am, client #3 did not wear her prescription eye glasses. During the observation periods, client #3 completed medication administration, punched out her own medications, read the menu with staff, watched television, and no eye glasses were observed offered or encouraged. | W0436 | **W436** The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. To ensure that Cardinal Services Inc. provides proper supports for Client #3, a Desensitazation plan will be written regarding the use of eye glasses and staff will be trained on the plan by 10/10/2011. A revised goal will be written, trained on and implemented formally offering Client #3 | 10/10/2011 |

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| | The QMRP (Qualified Mental Retardation Professional) was interviewed on 9/28/11 at 1:15pm. The QMRP indicated client #3 wore prescription eye glasses. The QMRP indicated client #3 should have been taught and encouraged to wear her prescription eye glasses. The QMRP stated client #3 had a "new goal" put into place 8/2011 for client #3 to wear her prescribed eye glasses for five (5) seconds.<br><br>On 9/27/11 at 10:45am, client #3's record was reviewed. Client #3's 4/4/11 ISP (Individual Support Plan) indicated she wore prescription eye glasses. Client #3's 12/7/10 vision exam indicated she wore prescription eye glasses.<br><br>9-3-7(a) | | prompts to wear her glasses four times daily by 10/10/2011. Informally Client #3 will be prompted to wear her glasses when reading or watching television. To ensure that this deficiency does not occur in the future monitoring will be done weekly, monthly and quarterly by the Residential Manager, QDP and Residential Coordinator. **Residential Manager, QDP and Residential Coordinator responsible.** | |